Regional EMS Council Process Action Team (PAT)
Doubletree Hotel, Charlottesville, VA
March 20, 2008
10:00 AM

Members Present:	Members Absent:	Staff:	Others:
Gary P. Critzer, EMS Council Board President, PAT Chair	Dr. Jack Potter, Designated Trauma Center Representative	P. Scott Winston	Melinda Duncan, NVEMS
Dr. Rob Logan, EMS Council Executive Director	Jerry Overton, Urban Based EMS Service Representative	Dennis Molnar	Connie Purvis, BREMS
Tina Skinner, EMS Council Executive Director		Michael D. Berg	Holly Sturdevant, ODEMSA
Dr. Scott Weir, Operational Medical Director		Irene M. Hamilton	Heidi Hooker, ODEMSA
Dr. Theresa Guins, Physician Member of EMS Advisory Board			Mary Kathryn Allen, BREMS
Donna Burns, EMS Council Board President			Karen D. Wagner, EMS Advisory Board Chair
Dreama Chandler, VAVRS President			Gary Dalton, LFEMSC
Randy Abernathy, VAGEMSA President			Jim Masten, PEMS
Chris Eudailey, Virginia Fire Chief's Association President			Jim Chandler, TEMS
Scott Hudson, Rural Based EMS Service Representative			John Wertman, UVA Medical Center
Bruce Edwards, EMS Advisory Board Member			Gregory Woods, SWVEMS
Jason Campbell, Virginia Professional Fire Fighter/VML Representative			Bill Downs, TJEMS
Gary R. Brown, OEMS Director			Dave Cullen, CSEMS
Dr. Lisa Kaplowitz, Virginia Department of Health (ex-officio member)			
Tim Perkins, OEMS Staff to Pat			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to Order – Gary Critzer, PAT Chairman	Gary Critzer called the meeting to order at 10:00 AM	

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Approval of Minutes	The Team was asked to review the minutes from the February 25 and February 26 PAT meetings; as well as the February 25 Public Forum minutes for approval.. There was one correction regarding the Virginia State Fire Chief's Association representative's correct title. Chris Eudailey is the President of the Virginia State Fire Chief's Association. The minutes were approved with the one correction. The corrected minutes will be forwarded to the team.	
Overview of the basic Regional Council Contract – Dave Cullen	Dave Cullen asked the team to refer to the copy of the Central Shenandoah contract that they received in their original packet. Dave said that it mirrors all the other regional council contracts. Dave gave the group an overview of the contract. Dave said that it is important that the group understands what the basic contract is; what the regional councils contract with the state office to perform; the specific services that they offer; and then each council will each go through and talk about the specific items that their council performs above and beyond the state contract mandates. ➢ Regional Infrastructure – Each region is paid a certain amount of money, approximately $60-$70,000 (Tim Perkins confirmed). This pays for the Executive Director, Administrative Assistant and a Field Coordinator. Basically, this line item pays the overhead expenses. ➢ Regional Medical Direction – o Regional Medical Director –Each council is required to have an Operational Medical Director at the regional level. This line item allows them to put into their contract for their Operational Medical Director in case one of the regular agency medical directors, die, change position, etc. The Regional OMD will step in and take over as the EMS agency medical director until another OMD can be found. If that doesn't happen, in the past the State Medical Director has performed that role. o Regional Medical Protocols – BLS and ALS Protocols – Every region has a set of protocols. The councils each have committees that formulate protocols for each region. o Regional Medical and EMS Supplies Restocking Program / Regional Medication Kit Exchange Program – These are based on the protocols. To date, they have not been able to get a statewide protocol. The regional councils have committee to address these tasks. ➢ Regional Planning – The regions do a lot of planning. Planning takes very little money but a lot of time and staff work. o Regional EMS Plan o Trauma Triage Plan o Regional EMS MCI (Disaster/WMD) Plan o Hospital Diversion Plan – Smaller regions have this plan; but unless there is a major disaster – it is probably not needed. o Surge Capacity Plan ➢ Regional Coordination – Answering phones, dealing with local government, attend a lot of	

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	government meetings (local and state). The providers usually choose to call the regional office with their questions. o Regional General EMS Performance Improvement Plan / Regional Trauma Performance Plan – They are about half of the contract. There is great detail as to the make up, rules; and what they have to address. This is challenging because no other committee do they have to actually meet a specific such as this. Each of these plans has at least three items that must be monitored. ➢ Rescue Squad Assistance Fund (RSAF) Grant Program – Assisting every agency that requests their assistance. They also have to have grant reviews at the regional level. They are also required to attend a special meeting of FARC a day before the grants are awarded to answer questions for FARC regarding grants in their regions. ➢ Critical Incident Stress Management (CISM) Program – Each region has at least one CISM Team. They coordinate a large number of volunteers and licensed counselors. ➢ Regional EMS Awards Program – The councils work with agencies and schools to make sure they have award nominees. Each region also hosts an Awards banquet. The programs are costly. ➢ EMS Instructor Networks at the Regional Level – The councils have to bring in at least twice a year the regional instructors at every level and set up test dates for them and locations. ➢ Regional Information and Referral – they have a dedicated Administrative Assistant that answer calls and offer assistance and referrals, weekdays. ➢ BLS Consolidated Test Site Administration – It is a costly operation, and takes a lot of time and effort. ➢ Category One CE Program – The way that works is you either make offer for courses or have courses and the students get reimbursed. It entails completing a complex forms.	
Discussion and Questions Following the Review of the Regional Contract by Dave Cullen	Donna Burns asked what percentage of time does an Executive Director spend on the contract. Dave Cullen said that he spends 90 percent of his time on the contract mandates. Gary Critzer asked if the base funding was the same for every region. Dave Cullen asked Tim Perkins to answer that question. Tim Perkins said that the financial information for each region is in the original packet given to the group. Gary Critzer asked if a base payment is made to each council. Dave Cullen said that Gary is referring to the Regional Infrastructure Payment. Gary Brown answered stating that OEMS use to do that, but they now base funding on personnel and non-personnel costs. Gary Critzer asked to get a more detailed explanation as to how this funding formula is developed and what each council receives. Tim Perkins said that each council's funding is based on what they submit in their budget requests and what the council believes it will require to accomplish their contract goals. OEMS uses the council's previous year's budget submission and their audited financial statements for the past two or three fiscal years. Tim said that he feels the council budgets are comparable to the cost of living and the number of staff at the council.	

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	Gary Brown stated that in the past the base funding did not reflect the true expenditures. OEMS changed the funding formula in an effort to have the council's budget more truly reflect the cost of doing business with the council. Gary deferred to the two council directors on the PAT for their opinion on this funding formula. Gary Critzer said that obviously dependent on the size of the region, some regions take more people to deliver services than a smaller region. He recognized, however, that when you look across the line at each council's budget and the budget differences, taking into account the cost of living, it does pose the question of why there are such vast differences in the budget amounts. Tina Skinner said that personally from her council's perspective her Board of Directors approves the proposed budget for the coming year; and that is exactly their view when sending in the contract to OEMS. It is based on a percentage of funds from the state contract; funds received from localities that support REMS; and fund raising funds. In their perspective, those amounts are based on the budgets that our boards approve for us. Rob Logan stated that a lot of the contract deliverables don't have a lot of direct costs. Therefore, the contract proposals are usually heavy on the personnel side. Tim Perkins pointed out that in the case of WVEMS Council a lot of their budget is not for their base funding; but instead for IT support for all of the regions and the EMS Symposium. Gary Critzer asked if the base contract provided for three staff members for each region; or does it differ from region to region based on the coverage area. Rob Logan answered stating that with the funding formula now being used it is up to the individual council to decide how they request staff funding. Gary Critzer said he thinks that the explanations provided clarifies a lot of the questions that some of the regions have; because he feels that they were under the assumption that it was a boilerplate base for funding. Gary Brown clarified that from time to time councils will be budgeted for special projects that they have been contracted with to provide; services that they usually provide for all the regions. Randy Abernathy asked what type of financial review process is in place relative to all of the distributed funds. Randy wanted to know if councils are required to submit financial statements. Tim Perkins said that contractors are required to provide a copy of the year end financial statement. Randy asked if the statements were reviewed. Gary said the statements are closely reviewed and are utilized in developing the council's budget. OEMS visits the councils during the budget process and go through their proposal. Dennis Molnar analyses the financial statement closely looking at the revenue and expenditures and comparing how it measures up against the requested budget. Gary Brown asked Dennis Molnar to discuss in more detail a contract OEMS has with a firm to audit Regional EMS Councils. Dennis explained that OEMS has contracted with the firm to provide audit	

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	services to look at Regional Councils, along with monitoring the RSAF Grant Program and Return to Localities to see how we are spending the money. Gary Critzer asked if Regional Councils are also subjected to audit at the request of the state because they receive state monies. Dennis confirmed that is true. Jason Campbell said that there seems to be a negative connotation associated with the contract. He asked if that could be addressed. He said that it seems some councils feel that their time could be better utilized in other ways. Dave Cullen said a lot of Jason's concerns will be addressed by the individual council directors during their presentations. Dave said that there are bits and pieces of the contract that causes frustration for the councils. Dave pointed out that the contract contains many QA/QI mandates on the regional level; and the councils are responsible for getting "buy in" from their volunteers. This is a point of frustration for the councils. Dave pointed out that they are non profits; and they are not OEMS. Dave said he has a contract with the Office of EMS; but he also has approximately 15 other contracts to perform other services for other people. Dave said he is not a part of the Office of EMS; but he is a contractor and he has a lot of additional duties. Dave emphasized the necessity to have additional contracts outside of OEMS because OEMS funding alone is not enough to substantiate a council office. Jim Chandler said his feeling is that the regions are there to serve the regions, the stakeholders of EMS within their regions; and not to serve the state. So the contract budget is a funding mechanism that should allow regional councils to serve their localities agencies. He does feel the councils have an obligation to work together with the state. Jim pointed out that they have a State Plan that is supposed to also incorporate the Regional Plan. Jim asked if it is a bottom up Plan, State Plan or is it a top down Plan The last couple of years it really seems the State Plan seems to be the top down. The Regional Plans are required; but the State Contract has no particular linkage to the Regional Plans. The State Contract has years worth of negotiations back and forth ; a reality of what agencies do, not reflected in a core set of basic requirements that describe what the regions agree are the things that they all do. Jim said that he thinks some of the issues come up because of the concern that some of the regions have with some of the parts of the contract, the QA/QI portion that is inserted in the contract that the regions have not asked for. Generally speaking from Jim's point a view, 80 percent of the contract helps the regions helps the regions serve the localities. Jim said that you need to keep in mind that the contract is a funding mechanism to help the regions serve the localities not to serve the state. Scott Winston said that he has a little different perspective. The contract as it is currently written is primarily for base contract services. The base contract services are specifically identified in the Code of Virginia. The Code requires the Board has to develop a comprehensive, coordinated emergency medical care system. There must be a State Emergency Medical Plan that incorporates the plans from regional councils. It further states that the Plan must include certain objectives. There are 17 separate	

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	objectives that are required to be completed. From the state's perspective, they are contracting with another entity to perform certain services that are mandated by code to ensure an effective emergency medical care system. It is very much a top down approach and contract. The regional councils are an agent of the Commonwealth as it relates to serving that role. Scott said he understands that there needs to be some recognition for variations; but in some instances you have to do certain functions whether you want to or not. In the Code it doesn't specifically address providing education and training as a primary basic services. It talks about mostly planning and coordination; performance improvement, trauma registry data, public outreach and technical assistance. Scott said that philosophically there is a difference of opinion in terms of the contract; because there is a specific reason why those services are in the base contract because they come out of the Code of Virginia. Gary Critzer asked how often is the contract reviewed to make sure it is up to date and who is involved in that process. Scott said it is reviewed on an annual basis. Tim said that last year, he worked with Tina Skinner, as the Chair of the Director's group, and a group of the council personnel gave input. Tim said that he feels that overall the Office of EMS has been receptive to items that the councils want in the contract. Melinda Duncan said that the regions interpretation of the Code of Virginia for the most part differs from the Office of EMS interpretation. Melinda talked about a struggle she has each year in trying to find funding to add an additional staff member. Chris Eudailey said he wondered if it would be helpful to see a side by side comparison of the major elements of the contract to see if they can support the section of the Code of Virginia. He also asked how much money is available. Gary Brown said to answer the question Four for Life legislation. Two percent goes to the Virginia Association for Volunteer Rescue Squads so that is how that money has to be used. Twenty Six percent goes to localities for EMS purposes and per Code language for EMS only. A 32 percent is for Rescue Squad Assistance Funds and must be used for that purpose. Ten percent goes to OEMS for administration. Thirty percent goes to programs for contracts, Emergency Operations, Planning and Development and everything else. So it is a matter taking that and determining how much can support the system. Chris Eudailey asked if this means that there is not a specific percentage earmarked in the Four for Life language as to what will go the EMS regional councils. Gary Brown confirmed that was correct. Chris asked was that still subjective based upon staff's review of priorities as to what their own needs are and how that relates to the contract. Gary Brown disagreed that it is subjective. Gary Brown said basically the contract reflects what the agencies, the providers have said that they want from the regional council in their area. Chris Eudailey said that to give back the amount of money that is appropriate for the councils, somebody has to make a decision on how much money is available; they have to put priorities in order.	

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	Gary Brown agreed. Gary Brown said that in 2002 they went from Two for Life to Four for Life, and they went several years not obtaining the additional revenue because it was diverted to Commonwealth Preparedness and some other activities. It was only this past year that they received full revenue from Four for Life. That represents 100 percent increase in funding for the EMS system. In that same time from 2002 until now funding for the regional councils contracts have gone up 277 percent. Jason Campbell asked who approves the budget amount. Gary Brown said that all of their budgets have to go to the Department of Planning and Budget for approval. Jason Campbell asked what would happen if a council was to decide they did not want to contract with the Office of EMS. Gary Brown said that the question had not been posed before so he doesn't know what would happen. Jason Campbell asked what would happen if a regional council doesn't submit a performance plan; what would happen to their funding. Tim Perkins said that there is language in the contract to address that issue. Mike Berg answered the question Jason asked about what would happen if a regional council decided that they don't need money from the state. Mike said that regional councils have been designated by the Board of Health to perform these functions. If a regional council decides that they don't need the money then they have negated their designation and cannot perform functions on behalf of the Commonwealth. The Office of EMS would have to find someone else to perform the mandated duties in the region. Mike said that is a possible scenario as to how that situation would play out. Randy Abernathy asked if there is a performance bond in case a regional council doesn't meet requirements of the contract.. Melinda Duncan said that they did have that stipulation in contracts one year. Gary Brown said that there is a default clause in the contract. Dr. Kaplowitz said that all of the state's contracts must be approved by the Office of the Attorney General. Dave Cullen reminded everyone that the Board of Directors of the regional councils ultimately sign the contract and to assure that the contract objectives are met, and not the council Executive Director or staff. The directors and staff just manage the contract. Bruce Edwards said that he has observed that the regions and OEMS have not yet established a collaborative working relationship. This PAT is helping them to work towards that collaboration; and that is a good thing. Bruce encouraged everyone to keep an open mind as they go through this process. During the Public Hearings everyone was voicing their frustrations; it was a "We versus Them" dialogue. Bruce said that now it is important to address and understand what OEMS needs; what Regions need; and what the Providers need. Bruce feels it would be beneficial to everyone that when the Regional Councils make their presentations, they take time to talk about any collaborative work taking place between their regions.	

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	Dr. Kaplowitz added that as state employees they are responsible for using public funds effectively. Dr. Kaplowitz emphasized that all funds received, federal and state, always comes with rules that have to be followed. Dr. Kaplowitz commented that she is pleased with the amount of collaboration and effort to form better collaboration that she has seen taking place between the Office of EMS, the Regional Councils and the EMS Advisory Board.	
Regional Council Presentations – Dave Cullen and Regional Directors	Gary Critzer asked each council to do something along with presenting what they provide above and beyond the normal state contract. Gary had four items that he would like each region to discuss as they go through their presentations. Gary asked each council to address the following in addition to their presentation. 1. Deliverables – items above the contract 2. Sub-council structure how it is managed. 3. Funding mechanisms above & beyond state funding – how they work 4. Concerns or issues about the contract beyond funding.	
BREMS – Connie Purvis	Connie said that she doesn't have any concerns about the contract. Connie said that yearly everybody has to produce a Trauma Triage Plan. Funding mechanisms above and beyond state funding: BREMS has a good relationship with the local foundations – special projects – that produces funding beyond state funding. BREMS serves over 2,000 people. It is a metropolitan area; and it is a college area, housing five four-year colleges. BREMS has six jurisdictions. They are one of the eight original councils. In 1984 they received $16,000 in funding. They worked very hard for Four for Life because it helps to fund desired programs. Connie said that most of the councils work very similarly. She looks at their contract with OEMS as their mission to reach the grass roots. Connie feels that the councils have evolved over the years at different levels. BREMS offer some programs through the council office. BREMS has vested into the local school systems and emergency services departments to provide support to the new EMT-B training programs. Students get college credits. BREMS does drug boxes and does an exchange program. BREMS is heavily invested into insurance. When college is not in session, people doing clinicals are not covered. BREMS is heavily invested in disaster preparedness. Connie emphasized the importance of remembering that the regional councils are the invisible structure of EMS. They are the true grassroots contact. Connie said they have been offered a buyout by a group. Gary Critzer asked Connie to explain about the buyout offer. Connie said that the hospital has offered to buyout the council so that they could operate independently of the state.	

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	Bruce Edwards asked Connie to discuss any collaboration between BREMS and other councils. Connie talked about collaboration with WVEMS in trying to standardize drug boxes. The drug box stock is similar. They also have overlapping agencies with WVEMS. Bruce asked if Connie could conceptually understand the possibility of having a service area outside of the current region area. Connie said that should could see a collaboration of certain things but not conceptualize the elimination of their council office. Connie said that the region would not want to become a sub council. Connie said that any agreement to establish a service area that encompasses different regional offices would have to be voted on by the BREMS Board of Directors. Connie said as an Executive Director she is an employee of the BREMS Board of Directors; and she cannot professionally state an opinion for the Board. Connie said that the opinion of many is that the regional redesignation plan is an effort to reduce and save money. Bruce Edwards said that he gets the feeling that a fear exists among the regions of a resulting dominance of some regions over other regions and a way to take money away from one region and give it to another region. Bruce Edwards asked Connie what have been the barriers that have prevented collaboration with other regions in the past. Melinda Duncan said that several councils have collaborated in the recent past in purchasing insurance. Melinda talked about the issue of having a sovereign board and the requirement that you must have separate audits. Bruce asked about having the same auditor; and Rob Logan said that there still would not be a cost savings. Tina Skinner said that they have looked at the health insurance and benefit plans for several years and ran into a lot of obstacles. One being not being a formal corporation; even though it would be a group plan, then it would be requirements as to how many would participate. When the employees were polled there were not enough to participate in the plan. Bruce Edwards said that his point was to get dialogue on the table just to see what efforts the regions have already made in the past for collaboration. Melinda Duncan they have done a lot of things as a collaborative effort in the past. Melinda said what the directors want answered is when talking about the economy of scales, more specific on the range you are talking about; is it going to be cheaper for all the regions to write one regional plan; is it going to be the triage plan. Melinda said that the directors would like more specifics; and then they can give a more earnest assessment of its workability.	
CSEMS – David Cullen	One of their funding mechanisms is the American Heart Association. They are a training system and it is outside the scope of the contract. Any monies made off of AHA go to support CSEMS training expenses. They have three full time training staff. They are in the OEMS budget and a small part of their time do go towards contractual obligations. They are also unique in that they get Four for Life funding shared by all of their agencies with the exception of one. Fifty three agencies instead of getting money from their locality, the money goes to CSEMS and they put it in an escrow account. CSEMS currently gets 35 percent of RTL to fund CSEMS training staff. The rest of it is held and CSEMS gets the interest. They do request from the CSEMS Board of Directors when they want to use their core	

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	funds. They also get funding from their local governments, 42 percent per person. They have no pressing contract concerns. QA/QI is a "pain". They do a lot of collaborative activities with all of their neighboring regions. They participate in the stat box program. They hope that within a year they will be fully participated. They do a drug box exchange and they are very active. Things are in the process between Dr. Potter the regional OMD for Lord Fairfax and CSEMS OMD Dr. Brand; and they should be collaborating on drug boxes in the future. They do medical director training with TJEMS. They have contracts with a lot of companies to do training. CSEMS has just signed a contract with the Department of Health, not the Office of EMS, to develop a format for a stroke plan at the regional level. They are participating with people from BREMS region and is based around a Bath County hospital. They get $7,000 for planning the plan; and they are giving them $25,000 next month so that they can make internet training on stroke available to all their regional EMS providers. The $25,000 will pay for software and the internet access; and they have put in a RSAF grant and hopefully at least half of it will be funded so that they can provide laptops so that providers in the rural areas can take advantage of this training. They cooperate fully with the other regions. CSEMS does not have sub councils.	
LFEMS – Dave Cullen	Dave made the presentation on behalf of Tracey McLaurin who was unable to attend because of a staffing shortage in her office. Dave explained that he is able to present on LFEMS knowledgeably because he had signed a contract with OEMS to help oversee LFEMS in the last year in the absence of an executive director. They now have a new executive director, Tracey McLaurin. Dave said that the two councils operate quite similarly. The two councils share the same policy manual, the same job description; but the salary structure is a little higher at LFEMS due to cost of living. LFEMS provides a CLIA waiver license. They maintain operations and maintain communications through their council. They actually own their council communications repeaters. They have a tight medical affiliation with their hospital systems. LFEMS does skill drills and protocols classes. LFEMS, CSEMS, TJEMS are about to approach Northwest Regional Hospital group for a project. Bill Downs will discuss the project when he does his presentation.	

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	LFEMS is a training site for Central Shenandoah Community Training Center. LFEMS works closely with Valley Health. LFEMS does a lot of public education and a lot of PR events and have a lot of PR materials. LFEMS has a nice stroke awareness campaign. Bruce Edwards asked Dave if he foresees future collaboration opportunities between LFEMS and other regional councils. Dave said that he does foresee other collaborative opportunities in the future. Dave said that he feels that CSEMS Board of Directors is agreeable to collaborative efforts; but he cannot speak for the LFEMS Board. Bruce asked about collaboration with TJEMS leadership. Dave said that they have very positive relationship; and they have discussed with them possible collaboration.	
NVEMS Council – Melinda Duncan	They do have an AHA CTC as part of their contract; but probably 95 percent of the funding comes from outside state sources. They have a requirement for a CISM team. NVEMS Council produces a EMS resource directory that has grown tremendously. Last year they added Montgomery County, MD, Prince George County, MD and Washington, DC agencies to their listing. Outside of the contract they developed a Multi-Casualty Incident Manual. NVEMS also developed an EMS Supervisor Course. NVEMS developed and coordinate Regional STEMI & Stroke Programs; and they also participate in Washington, DC Council of Government activities. They also produce a hospital MAP book that they give to their agencies. NVEMS does not have sub councils. Contract issues is probably related to the PI program. They have had some problems on the trauma side; but should have them addressed soon. Funding above and beyond the state contract, NVEMS asks each of their hospitals for $5,000. They take a percentage of Four for Life funds, 2.5 percent from each of their agencies. Melinda feels that there is good collaboration among the regional directors. A lot of collaboration comes from the Regional Directors group meetings. The council government areas is where most of their collaboration efforts are focused. Melinda was asked about collaboration within career Fire & EMS departments. Melinda said that they are getting involvement from them especially with the Supervisors course. Bruce Edwards asked if there were any existing barriers to prevent NVEMS from collaboration with other regions. Melinda said no with the exception that the Fire Chiefs throughout the region like to do things their way. Melinda said that she does attend the NOVA Fire Chiefs meeting at least a couple of times a year to keep them abreast of NVEMS news and events.	

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	Bruce Edwards asked about collaboration with DC/MD. Melinda said that Maryland has regional councils like Virginia; and they do work a lot with Region 5 in the Montgomery County area. She does attend some meetings in DC. Melinda was asked the role of her Regional Medical Director in the decision to not have regional protocols. Dr. Weir answered this question. He explained that this is a mischaracterization. He explained that agencies are vastly different even though they look similar on paper. They have different capabilities and must be trained differently. He explained that the Regional Protocols needs to be written taking this into consideration.	
ODEMSA – Heidi Hooker	Heidi Hooker is the Interim Director of ODEMSA. The Executive Director retired on January 2, 2008. They expect to have their new director in place by March 31, 2008. They do have a sub-council structure. ODEMSA has four planning districts and each district has a sub-council that meets either quarterly or bi-monthly. Each council president has a seat on the Board of Directors and each council has a second representative on the Board of Directors. Heidi said she feels the sub-council structure works well. She feels that it gives everybody a voice. Heidi said that the sub-councils are established by the planning district. Heidi said that each agency names their own representative to the Board. Beyond the contract, ODEMSA holds ALS and National Registry training. ODEMSA has an active lending library with books and videos for the providers. ODEMSA is an EMT-I accredited site. ODEMSA does a lot of continuing education. They get a lot of calls, especially calls dealing with training. ODEMSA sponsors a Super Weekend when they offer 24 – 27 hours in one weekend. This is extremely popular among their providers. ODEMSA hosts a STEMI Seminar. They obtained a RSAF grant that will allow them to purchase 12 Lead monitors for each agency in their regions. ODEMSA has a good working relationship with the community within their region. They have a contractor that schedules clinicals rotations for all the students in the region. The hospitals enjoy that process. ODEMSA has an Infections Disease Registry – each agency is required to submit to each hospital the names of three people to contact if there is an infectious disease problem. ODEMSA does that for their agencies, they ask them to submit the names to ODEMSA and not to each hospital; and they print a book that they submit to the hospital. Gary Critzer asked if they have any funding sources outside of the state. Heidi said that the hospitals have been very generous. Heidi said that the Board of Directors met recently to discuss establishing outside funding sources. Heidi was asked if the sub-councils contribute to ODEMSA's funding. Heidi said they don't contribute	

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	to ODEMSA but they do all have their own funding. Gary Brown said that the Code of Virginia requires that the councils have representatives of local jurisdictions. Gary asked Heidi to explain to the PAT the current financial situation of ODEMSA. Heidi said that ODEMSA currently has a cash shortage. The Board of Directors or the staff was not aware of the situation prior to the former Executive Director's retirement. They are working on the situation and they have had to make some cutbacks. The other regional directors have been very helpful. Bruce Edwards asked Heidi where the central office was located; and if they had other offices. Heidi said that the central office is located in Richmond. ODEMSA does not have other offices. They have two full time field coordinators stationed in Richmond and a PT field coordinator who works from home for Planning District 13. Bruce asked if they hold training in Planning District 13. Heidi said they do hold training in that area. She indicated that a lot of times when training is offered in a rural area, they don't have people to show up for the training. Heidi said that the sub-councils meet bi-monthly and it is staffed by the ODEMSA office. Heidi said that she has heard that Planning District 13 is unhappy; but Heidi has communicated to them that they have an equal voice with ODEMSA. Randy Abernathy asked when has a new person sat on the ODEMSA Board of Directors. Heidi said that their has been different people on the Board of Directors. Planning District 13 has not had new people on the Board. Gary Brown went on record to commend Heidi Hooker on the great job she has done at ODEMSA as Interim Director during a very difficult period; and recognized some of the great strides she has made in that short time.	
PEMS – Jim Masten	Beyond the state contract, they do regional drug boxes. However, unlike a lot of the other regions, when you open up the drug box you have the same thing in every area of the region; and that they are packed the exact same way. They do disaster coordination. Throughout the region, all the areas need Events; and PEMS coordinate the programs. The paid agencies ask for a lot of drills that are coordinated by PEMS. The hospitals are asking PEMS to sit on their standing committees and helping them out with some of the events they sponsor. Contract issues they have are related to QI. Jim said that the contract states that members must be active on committees 75 percent of the time. This is hard to enforce. There is some sub-council structure. When it comes to medical direction it is one committee for the	

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	entire region; when it comes to mass casualty it is one committee; trauma plan it is one committee for the entire region; when it comes to operations they divide into three separate regions. Each of those three committees appoint two people, usually the Chairman and Vice-Chairman of the committee to serve on the Board of Directors. Other people on the Board of Directors include each hospital administrator is asked to appoint someone from their hospital; and they also ask that cities or counties have representation. They have two county administrators on the Board of Directors. They also have citizen members. Jim said it is not truly a sub-council structure. Funding above and beyond the state contract, they receive $45,962 above state funding. Approximately $8,000 come from rent space; and they also do per capita to localities. No contract issues. There is some frustration with the 25 percent matching funds. The other issue with the contract, is that their assignments have not yet been made for what the agencies have to do on their assigned projects. They are trying to track STEMI and how they come in but until all of the hospitals give them the STEMI information they can't complete the project. Rob Logan asked about their bullet point list, two or three things that they are doing, partnering with various organization, MMRS. Jim said that they have made all of their drug boxes the same, the same drugs, but they got away from it for a short period of time. They are trying to make sure that their protocols at least can treat modalities. There may be some differences on who has to call when but at least try to get their treatment modalities the same because they are on MMRS. At the same time they have realized some problems with that because the majority of their agencies and area are not an MMRS. In rural areas they don't feel the MMRS will work. Jim was asked to clarify because at the Public Hearing most of the speakers were concerned about the possibility of having to adopt TEMS protocols; and yet now it is reported that the medical directors have already been working towards that direction. Jim said that modality wise they are very much the same; but there are one or two drugs that they have differently. Jim said that they are not trying to attack TEMS; they have worked well together. The message that the Board is trying to put out and he has been asked to relay to the PAT is that at this time with the information that they have been given they don't see any benefits to the proposal and actually realize the negatives. Bruce emphasized that there are not a lot differences between the two regions, PEMS and TEMS. Bruce asked Jim to elaborate on how the sub-council system works in PEMS. Jim said that it is essentially three operations committees. They all come together to work out issues. Jim said that the PEMS region is frustrated. Nobody has been told what the reasoning is behind the proposed changes; or what is the objective of this PAT. Gary Critzer said that the purpose of this committee was stated in the first meeting. The purpose of this committee is to take comprehensive and complete evaluation of the regional council system, recommendations for any modifications that may or	

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	may not be necessary in the regional council system. To take a comprehensive and complete look at the regional council system. Gary Brown said that he would like to rebut the statement made that you don't control what people say at the Public Hearing. They seemed to come in buses. Secondly, Gary said he has seen no less than a dozen written comments from various agencies and jurisdictions that seem to be boilerplate copies. Gary said in respect to the comment about the contract match, they have to remind the PAT committee is that the designated council is required to match the state funds with local funds from private and public sources in the apportion specified in the regulations of the Board. Each of the regional councils, the Advisory Board all worked collaboratively to develop those regulations and they went through the Administrative Process Act and that has been promulgated by the Board of Health. In terms of why we are here, the information is out there and it has been shared. It is up to individual choice to accept or reject the information. Dr. Guins said to take the message and separate it from the man, it is important that agencies and front line providers feel some alignment with their regional council. There is the potential as your business growsto lose that "lollipop" boutique shop close feel. As economies of scale become more apparent, as you get larger you have the potential to lose that close intimate touch with your consumer. Somewhere there is a balance in the boardroom. .... It is a difficult task to our Commonwealth and all our agencies there are a lot of people who really care. That is a good thing. A lot of people who can articulate that the need the regional council whatever structure that it is.	
REMS - Tina Skinner	REMS is made up of 26 Board members. Each locality appoints two representatives to the board. They also have six at large members that come from within the region and the community. The regional medical director also holds a seat on the board. The President does appoint active committees every two years. The chair of each committee is a board member. Some of the things that they do that is above and beyond the standard contract items. REMS provides administrative support for their 12 operational medical directors. REMS has implemented a regional skills performance program; it will be fully implemented region wide in 2009. REMS maintains an accredited regional training and simulation center. Six months ago they moved into a new facility. Typically in their old facility they would see 400 students come through the center; in the new center in six months they have seen 400 already. REMS is looking at becoming a designated site and hold a site license for certified intensive paramedic programs. REMS oversees and schedules clinical rotations for all the courses conducted in their regions. As a region they provide standardized testing at the ALS level which is above the contract which is for	

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	BLS testing. In the coming year budget they have budgeted for National Registry Testing. They oversee a regional ALS pretest program. As a region, through their operational medical director has an ALS Release Program that the council is responsible for overseeing and coordinating. They work closely with health care partners. They have one university and some community colleges in their regions where Tina sits on committees. They participate in regional projects representing EMS system with their health care partners. They also work very closely with their health district. PEMS will be growing from three hospitals in the region to six hospitals; and they will have a Level II Trauma designation coming soon to Mary Washington Hospital. REMS is a combination system, they have both rural and urban areas. They have career, volunteer and federal agencies. All the federal agencies support the regional council and follow the protocols that govern Virginia. REMS and their Board are very receptive to be diverse in seeking income resources. They have a benefit gold tournament yearly. This is the six year of this tournament. REMS is also a United Way agency. Tina said this presents a great opportunity for networking, even though limited funding is received through that venue. They provide the EMS support the National Boy Scout Jamboree that comes to their region every four years. They are already planning for the 2010 event. The event takes place over two weeks, and they have 40,000 attendees. During the event they set up a small city and doing everything that they do for their service area for this event. REMS has six full time employees. They have one office in the City of Fredericksburg. They do not have any sub-councils. They have on staff 8 part time training staff that support the regional training center. They have one company vehicle that is used strictly for company business and stays on site. Fifty two percent of their income comes from the state contract. The remaining 48 percent comes from local government support and their outside funding. They apply for grants to support the system; and they do receive some in kind support from hospitals. They have no specific contract concerns. REMS was a part of the former federation which was one large region. However, essentially all of the smaller council offices that made up that former Federation were their own entity, and they operated individually. Tina said that was before she became a director; but she feels that some of the directors who were in the Federation could probably address some of the issues that are now being discussed.	

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	Bruce Edwards asked about commonalities with other regions. Tina said that her Executive Board has had several meetings regarding the possible boundary changes. They felt strongly that they worked so hard to expand originally gaining what was part of the federation in the past, they did not want to see them lose that. In looking at the NOVA concept they felt that it was more important since they were open to growth, open to those opportunities that being with a system that they have more in common with. The Executive Board felt that they have more in common with the TJEMS Council as part of the federation. They already collaborate now on some items. Tina thinks that if they sat down with the Board they would find several similarities. NOVA is predominantly urban and much larger. TJEMS more closely mirrors what REMS looks like. Tina said that the President of REMS Board of Directors has reached out to TJEMS about the possibility of looking at a collaboration.	
SWVEMS – Greg Woods	SWVEMS Council encompasses 16 localities; and the Board has 31 members with membership coming from each of those localities. They also have some at-large positions. The Bylaws establishes seven standing committees. They do not have a sub-council structure. They receive funding from each of their 16 localities. Last year they started reaching out to incorporated towns, and have some financial support coming out of those towns. They also have some support from their hospitals. SWVEMS has 17 hospitals. They receive funds from two United Way agencies. Their other funds from the ALS training program and registration fees that are associated with that program. They have no specific concerns with the contract. Specific services above and beyond the contract. Each year they create a training schedule; and they have all types of training courses throughout the year. Each year they have a training committee that tries to participate the needs of their providers in the field. Their main office is located in Abingdon Virginia. From many parts of their region the commute to Abingdon is about two hours. To answer that issue most of their training they offer in three sites that are more centrally located to the individuals. They do the same thing with their testing. SWVEMS has a staff of five. Three of those are field coordinators. Part of their essential duties, they have been designated parts of their region that they are primarily to serve. So that any issue related to emergency medical services that the provider has they have an individual that they can contact. Because of that SWVEMS travel projections last year were off by several thousand dollars as they tried to take the council to the areas that they serve. They manage an EMS lending library that includes instructor resources, training mannequins, and videos. That can be utilized by instructors. The video library can be utilized by any provider.	

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	Bruce Edwards asked about any collaboration with Tennessee and North Carolina. Greg said they work with Tennessee more. They do have providers who live outside the state. They have a lot of collaboration with WVEMS. They have had conversations about streamlining some of their processes and working closely with WVEMS. Gary Brown said that the PAT committee needs to be exposed to some success stories. Gary said that seven years ago OEMS found some performance problems in SWVEMS, and decided not to contract with them because of some leadership issues at that time. OEMS contracted with Rob Logan to work with the Board to help them get back on their feet. Today SWVEMS is a model for a regional council. Gary said that Greg Woods has a "can do" attitude and Gary commends him, as well.	
TJEMS – Bill Downs	They represent one planning district plus Madison County. Madison had historically been part of the Rap-Rap Council. When the merger occurred between REMS and RAP-RAP that council chose to come with TJEMS. They have also had discussions with Culpeper and Buckingham as to whether they feel they would be better served in their regional council. In their council they have a Board of Directors which every transport agency has a seat; every locality has a representative; and the regional medical director has a seat; as well as another OMD. The Board is composed of 33 members. TJEMS has an Executive Director, a Program Coordinator and an Administrative Assistant. They have four part time BLS trainers. They share office space with the University of Virginia Prehospital program. They have a great relationship with UVA. BLS Continuing Education mirrors ALS education which historically has been an in kind donation by UVA. In the late 1980s the council designed and hired the first Basic Life Support Training Coordinator in the state. That person by creating that position drew in tremendous buy in from localities. Ten months out of the year there is BLS CE training in every locality. TJEMS took concepts like Skills Drill, historically an ALS requirement, and created it for the BLS environment. They have a relationship with the UVA Research Center. They work in collaboration with UVA on several initiatives. TJEMS has a 30 percent buy in.that is in large part related to their BLS training. TJEMS is a small city surrounded by rural agencies; and they are dealing with the issue of combining career and volunteer providers. To work those issues out, Bill attend officers meeting every month. The outside funding they receive is primarily for their BLS Training. Concerns that they have is how can they fulfill the contract and get buy in for the performance improvement requirement that was recently added. Bill said that their buy-in has historically been the training that they offer. Bill pointed out that in other state level committees that they participate in as well as in other areas of health care the buy in is federal funds. TJEMS does not have that kind of buy	

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	in. Collaboration takes place with the other regions almost daily. Being a new director he has had to reach out to the other councils; and they have always been willing to help. TJEMS participates along with three other regional councils on the Northwest Hospital Emergency Management Committee. They participate in their meetings, but they are not voting members. One of the issues they are looking at is where their regional healthcare communication centers are located. They are asked to reevaluate where they are located and how they are staffed. Bill Downs said that he asked a question and ended up being part of a working group looking at the regional healthcare communications center. There is an issue there of how they are going to staff the center. TJEMS, along with the other two regional councils on that committee, thought this might be an opportunity to approach the committee and offer their services as a resource. Bill said that he can't promise that they will be able to sell this concept to the Northwest Hospital Emergency Management Committee; but those are the type of opportunities that they are looking for and are willing and ready to partner up to perform. Bill Downs was asked a question regarding TJEMS considering making BLS training a separate entity of TJEMS. Bill said that is an issue that preceded him. Donna Burns explained that OEMS met with TJEMS about a year ago and told them that training was not a mission of the Office of EMS. The funding that they provided with contracts was not for training. TJEMS, therefore, explored the idea since if they were going to have to account for how much time was spent on contracts as compared to what they spent on training, then it didn't seem like a danger at the time to possibly set up a separate training entity. However, the former Executive Director was not in comfortable creating a separate entity for the purposes of contracting to provide EMS training and continuing education. Donna said that her personal goal is for TJEMS to have a Regional Training Center. Bruce Edwards asked about the possibility of collaboration with BREMS. Bill said that they are willing to sit down and talk to anybody about what will be more effective. On the surface they are not sure it will be more effective; what efficiencies will be realized and at what cost.. TJEMS has already had conversations with other regions. TJEMS interest is more in whenever possible seeking out partnerships and alliances that will allow them to build up or build down in response to the system's needs. Scott said OEMS recognizes that training is important and that they do provide funding outside of the contract to facilitate training within the region. Scott asked if it was true that they had four part time employees that are providing training. Scott asked how many hours a week or month to they perform. Bill said that they each do about 12-16 hours per week. Scott asked if all of the jurisdictions within the regions providing funding. Bill Downs said yes they do.	
TEMS – Jim Chandler	TEMS have a lot of committees that do work that are not in the contract. TEMS work jointly with PEMS on the mass casualty plan. Jim said he wanted to correct something that was said earlier [that	

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	the MMRS program was forced on regions. He said that it was actually the reverse the two EMS regions in the MMRS plan are served by one MMRS team. On behalf of the medical directors they do regional testing for ALS candidates. TEMS does a lot of work with the EMS Symposium. TEMS does a series of Infection Control designated officer courses. TEMS provide administrative support to the VA-1 Disaster Medical Assistance Team. They do drug boxes and IV boxes. Their boxes are locally funded. TEMS manage the funds for a Regional Technical Rescue Team. Two of the non EMS programs TEMS oversee is to manage the Tidewater Center for Life Support Training along with EVMS. TEMS also manage the Hampton Roads MMRS program, which include 16 jurisdictions that include part of TEMS, PEMS and ODEMSA region. TEMS does have a sub-council on the Eastern Shore. They have a western Tidewater area and they have attempted to set up a sub council there without a lot of success. Other funding EVMS, MMRS Program, federal grants and locality funding. Concerns about the contract – concerns about PPI part of it. Bruce Edwards asked Jim to relate to collaboration. Jim said they collaborate a lot with PEMS but not much with ODEMSA. Jim said that Surry is in the border area; and he does see the opportunity regarding the western Tidewater area but does not warrant TEMS setting up a sub-council; and he thinks it would be good to look at some sort of collaboration between ODEMSA and TEMS to support those areas.	
WVEMS – Rob Logan	WVEMS was founded in 1975. They have three Planning Districts and 16 localities. They have a 27 member Board of Directors. Things that they do above and beyond the contract – a lot is education related to OEMS education. They have agreements to offer college credits for events and remedial training. WVEMS goal is to get out of the certification business all together. They have 12 hospitals in their region and have come up with agreements with all the hospitals. They are looking at collaboration for drug boxes with SWVEMS; WVEMS and BREMS. Funding beyond the contract, they have a formula based funding from each of the four localities. They have grants and pre hospital care . Bruce Edwards asked about the possibility of collaboration. Rob said that there has been no formal discussion. He doesn't see a lot of problems; but he said that you cannot keep two boards and run it as	

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	one council.	
Response to Questions Posed at February 25 & 26 meetings.	Three questions that came back from the February 25 & 26 meetings were: 1. What is going on in other states. Tim said there is not a lot of information 2. Asked for wording for the budget amendment by Senator Abbitt. That language stayed in the budget. 3. Randy asked what are other states doing as far as the IOM report. Gary Critzer sent this information to PAT.	
Next Meeting – Tim Perkins	Tim talked about the agenda items for the next meeting. Economy of Scale; Cost Effectiveness; PI issue; CTS; Board of Directors; RSAF; Protocols; Financial Situations; Special Contracts; Financial Statement with Local Government; Report guidelines for funding contract deliverables. Quality of work; Menu of services; Dennis will provide information about Return to localities. Dr. Kaplowitz wanted to assure that the Commissioner issued a variance postponing the regional council issue. Gary Critzer said that Tim Perkins will be first on the agenda at the next meeting. At the next meeting they need to delve into the Regional Council contract process and actual deliverables; do they truly meet what we need to be doing in the RC System. They need to look at deliverables for councils. They will also look at the service area issue.	**The PAT was asked to review all the information they have received and make suggested changes.** **Look at deliverables of councils.** **Look at Service area issue.**
Meeting Date	Tuesday, April 29, 2008 at 8:30 AM in Williamsburg, VA	
PUBLIC COMMENT	No comments.	
Adjournment	The meeting was adjourned at 5:45 PM	